Utilization Management

The daily functions of Utilization Management (UM) report through the Medical Affairs Department and are under the direction of the Vice President of Medical Affairs, the Maricopa Integrated Health System – Health Plans (MIHS-HP) Medical Director and the UM Director.

The purpose of Utilization Management is:

- To provide an active process which assesses, educates and intervenes with the providers of health services to increase the efficiency, appropriateness, effectiveness and timeliness of high quality health care.
- To identify opportunities for improvement in care and services through performance measures and to integrate all utilization activities where applicable to assure effective communication, resolution of issues and availability of appropriate resources.
- To promote the efficient utilization of resources through prospective and concurrent reviews of the necessity for inpatient admission, appropriate length of stay, and timely and appropriate use of diagnostic and therapeutic services.
- To assure that the medical record substantiates, through clear documentation, the quality and utilization of services needed for the management and progress of each patient.

Utilization Management Coordinators are registered nurses who collaborate with physicians, social workers, case managers and other health care team members, across the continuum, to perform the following functions:

- Assessing the patient's current need for hospitalization services based on nationally established and accepted standards of severity of illness and intensity of service.
- Screening the patient's chart for quality of care indicators that must be monitored and reported by the healthplan.
- Facilitating discharge planning and the coordination of resources required to continue the patient's care in the non-hospital setting.

Decisions related to the appropriateness of a hospital admission and continued stay are based on the nationally accepted standards and guidelines of InterQual®. These criteria provide the UM nurses with guidelines for assessing the appropriateness of the patient's hospital admission and need for continued hospital care. These criteria have been used by managed care organizations for over twenty years and they are well established as to their accuracy and utility. The Health Care Financing Administration (HCFA) and multiple medical and professional organizations accept them.

The InterQual® criteria uses clinically relevant indicators for the patient's severity of illness (SI Indicators) and intensity of service (IS Indicators) to evaluate whether the patient still requires continued care in the inpatient setting. In addition, the InterQual® criteria contain discharge criteria and screens to evaluate the stability of the patient for transfer or discharge from the hospital. Patients not meeting criteria for continued hospital care are reviewed by the MIHS-HP Medical Director for discussion and evaluation. The UM nurse will consult with the patient's attending physician to determine if assistance in transfer or discharge planning can be provided.

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One of the important tasks of the UM nurse is to help the patients, and their attending physicians, with coordination and planning of post-discharge care. For this reason, the UM nurses can be tremendously helpful and a valuable asset to attending physicians.

It is vital to note that patients not qualifying for the continued inpatient level of care, according to the InterQual® criteria, will probably still need continued medical services. The failure to meet criteria for continued hospital services means that the patient can receive effective medical care in a more cost-effective setting. Depending on the clinical situation, other settings include subacute or skilled nursing care, home care, acute rehab care, and the physician's office.

When the MIHS-HP medical director deems a patient's continued hospitalization to be inappropriate after interaction with the UM nurse and attending physician, MIHS-HP is obligated to deny payment for continued hospital services. Managed care health plans are required to trend and manage provider utilization issues by their various regulatory agencies. For this reason, physicians who demonstrate a pattern of adverse utilization must have that trend reflected in their credential files.

One of the important tasks of the medical director, and the UM team, is to work with providers to teach them managed care techniques and methods, as well as to help them practice cost-effective medicine. A cooperative effort between MIHS-HP and its participating providers obviates the adverse utilization trends and the unwelcome intervention of regulatory agencies. It also results in more quality, cost effective care for our patients.